

The Wyoming Legislature will support reforms that establish high standards for treatment, that require the use of research based, state of the art prevention, early intervention and treatment methods, that evaluate outcomes, and produce results.

"What I learned...convinced me that in coerced treatment rests the elusive secret to effective rehab. That secret, however, lies not only in coercing addicts into programs, but in coercing the programs to do rehab right!" 164

# Lessons learned from New York subway cars

This plan asks the citizens of Wyoming to invest millions of dollars in a comprehensive plan to deliver substance abuse prevention, early intervention, and treatment services. This plan also asks that the legislature *not* appropriate a nickel unless they first implement the reforms necessary to assure themselves and others that the system in which they are investing the people's money will make a difference.

Those who work in this field will tell you that addictions therapy must be structured to hold the substance abuser accountable. Accountability is the by-word for this plan. We believe, however, that before policymakers can expect addicts to be held accountable, the treatment system

itself must be accountable. A structure must be created that delivers state of the art, research-

based treatment that meets client rather than program or practitioner needs. Treatment plans must include case management services that wrap addictions treatment around an effort to meet other significant client needs such as mental health care, housing, employment, education, and others. The services must provide sufficient continuing care to reasonably assure that all of the money and efforts expended in primary care is not wasted.

To use Malcolm Gladwell's metaphor of the New York subway cars from the book The Tipping Point, we must make the commitment not just to reclaim lives but also to make certain those lives stay reclaimed. Gladwell's book is about how social change takes place, what it takes to create a movement that results in positive social change. He discusses the New York subway system, recounting the days of the 70's and early 80's when New York was gripped by crime and the subway system a symbol of the deterioration of the city. The

subway cars were filthy, graffiti-riddled and crime-infested. A newly hired, innovative director, David Gunn, decided the way to clean up the system was to focus not on the crime but on the graffiti. Critics thought "worrying about graffiti at a time when the entire system was close to collapse seems as pointless as scrubbing the decks of the *Titanic as it headed for the icebergs*." 165

But his approach worked. As the cars were cleaned up and restored, good customers returned, paying fares and occupying reclaimed subway cars formerly filled by criminals and trouble makers. The key, though, was not simply restoring the cars.

"Gunn made it a rule that there would be no retreat, that once a car was 'reclaimed' it should never be allowed to be vandalized again." 166

That is the commitment policymakers are asked to make to Wyoming families. Once reclaimed, we will do what it takes, commit the necessary human and financial resources, to make certain lives remain 'reclaimed.' It is not just a human issue with moral implications. It is an issue of the responsible use of taxpayer dollars...that also has moral implications. There was a time when we agreed that whether or not treatment worked depended almost entirely on the addict. We know more now. We know better now. An explosion in scientific study over the last decade has produced significant results in the form of research-based practices that greatly improve the chances of successful

treatment even when the addict does not initially want it. Substance abuse treatment and prevention programs are far too expensive to continue to use approaches that have traditionally failed.

None of this should be read as criticism of Wyoming treatment providers. Those who have undertaken this comprehensive study have universally concluded providers are doing remarkable work with the tools and the resources they have. However, those tools and resources have been far too limited to expect the highest level of results.

#### **Findings**

After conducting this inquiry, the Substance Abuse Division has made the following findings:

- ⇒ Wyoming addictions treatment, early intervention and prevention services have been historically under-funded.
- ⇒ Under-funding results in only token services available in small counties and an inability to deliver integrated services in every county on a collaborative basis, resulting in an inability of the system to provide a continuum of care necessary for effective treatment.
- ⇒ Under-funding prevents the provision of the ongoing education and training necessary to keep those working in the system up to date on state of the art programs.

- ⇒ Under-funding creates barriers to recruiting and retaining not only sufficient numbers of staff but also the best and the brightest professionals that are needed to assure the continuing success of programs.
- ⇒ Under-funding produces a burden on providers who attempt to meet the growing demand for treatment.
- ⇒ There are significant gaps in services such as a near absence of intensive outpatient programs; residential care capacity is inadequate both in terms of the numbers of beds and the length of stay allowed; case management is inconsistent when available; transition programs are sporadic; drug testing is ineffective; waiting lists prevent people from getting into treatment at the most critical time: when they are ready and motivated.
- ⇒ Under-funding, however, is not the only problem. Simply putting more money in the system will not fix it and will not, of itself, result in more effective programs. Reforms are

- necessary to hold the system accountable to taxpayers for the investment they make. Other problems include:
- ⇒ There is no agreement on priority populations for dedication of resources.
- ⇒ There is a lack of agreement on the nature of addiction, leading to inconsistent approaches that often fail to use good science.
- ⇒ There are no research or sciencebased standards for treatment or the delivery of services.
- ⇒ Legislators who fund programs and judges and others who refer to them do not require programs to demonstrate effectiveness
- ⇒ There is little monitoring of programs and virtually no effective outcome studies. In short, programs are not required to demonstrate that what they are doing actually works!

#### **Exploding Myths about Drug Abuse**

By Alan I. Leshner, Ph.D.

**Director, National Institute on Drug Abuse** 

Myth: Drug addiction is voluntary behavior.

A person starts out as an occasional drug user, and that is a voluntary decision. But as times passes, something happens, and that person goes from being a *voluntary* drug user to being a *compulsive* drug user. Why? Because over time, continued use of addictive drugs changes your brain — at times in dramatic, toxic ways, at others in more subtle ways, but virtually always in ways that result in compulsive and even uncontrollable drug use.

Myth: More than anything else, drug addiction is a character flaw.

Drug addiction is a *brain disease*. Every type of drug of abuse has its own individual mechanism for changing how the brain functions. But regardless of which drug a person is addicted to, many of the effects it has on the brain are similar: they range from changes in the molecules and cells that make up the brain, to mood changes, to changes in memory processes and in such motor skills as walking and talking. And these changes have a huge influence on all aspects of a person's behavior. The drug becomes the single most powerful motivator in a drug abuser's existence. He or she will do almost *anything* for the drug. This comes about because drug use has changed the individual's brain and its functioning in critical ways.

Myth: You have to want drug treatment for it to be effective.

Virtually no one *wants* drug treatment. Two of the primary reasons people seek drug treatment are because the court ordered them to do so, or because loved ones urged them to seek treatment. Many scientific studies have shown convincingly that those who enter drug treatment programs in which they face "high pressure" to confront and attempt to surmount their addiction do comparatively better in treatment, *regardless* of the reason they sought treatment in the first place.

Myth: Treatment for drug addiction should be a one-shot deal.

Like many other illnesses, drug addiction typically is a chronic disorder. To be sure, some people can quit drug use "cold turkey," or they can quit after receiving treatment just one time at a rehabilitation facility. But most of those who abuse drugs require longer-term treatment and, in many instances, repeated treatments.

Myth: We should strive to find a "magic bullet" to treat all forms of drug abuse.

There is no "one size fits all" form of drug treatment, much less a magic bullet that suddenly will cure addiction. Different people have different drug abuse-related problems. And they respond very differently to similar forms of treatment, even when they're abusing the same drug. As a result, drug addicts need an array of treatments and services tailored to address their unique needs.

# The current treatment system

To understand the recommended reforms, the reader need first become familiar with the existing system. Currently there is no unified structure. There are public and private programs providing substance abuse services, some of which were designed for that purpose and some of which were not, but of necessity have been brought into the mix. Wyoming is fortunate to have developed a community-based delivery system that has a statewide presence. It is important to note this system provides a substantial foundation from which the state can readily move toward a fully comprehensive system.

For the most part, addiction treatment services are delivered in Wyoming through the community mental health and substance abuse centers. The centers provide 16 prevention programs that operate in all 23 counties. This year they received \$378,773 in state funds and \$215,941 in federal dollars. Treatment is provided in 17 outpatient programs, four adult residential centers, and one adolescent residential center. Outpatient treatment programs received a total of \$1,765,936 in state funds and \$112,624 in federal monies while the residential programs were allotted \$1,591,850 by the state and another \$715,680 from Washington.

Residential capacity is severely limited. The four adult centers offer 48 beds. Two of these centers are 28-day programs (Cheyenne and Casper) while

the other two, at Sheridan and Rock Springs, are long-term care facilities. The sole adolescent residential program is at Casper and has only 8 beds. Additionally there are 3 transitional programs. There is one at Cheyenne, another in Sheridan, and a third on the Wind River Reservation. Only two detoxification centers operate in the state, one at Cheyenne and the other in Riverton.

Funding for the state's substance abuse services has been historically poor. While the national average for combined treatment and prevention services is more than \$11 per person, Wyoming expenditures are just \$5.81. 167 It is, of course, important to note that these are not the only dollars the state spends on the problem of substance abuse. This problem requires considerable expenditures for child welfare and family assistance, health care, special education, prisons, jails and other corrections, and law enforcements efforts. A recent study of the impact of substance abuse on the state's budget concludes that while we spend just \$5.81 per capita on treatment and prevention, Wyoming taxpayers cough up a whopping \$240.06 per person for all of the other related costs!168

Table 1 is a county-by-county analysis of current state and federal funding of both prevention and treatment dollars. Per capita expenditures for treatment range from a high of \$4.54 in Laramie County to a low of \$1.98 in Platte County. The average is just \$3.58. Several counties receive so little, they are unable to afford even a single trained

substance abuse therapist, much less the development of meaningful treatment program.

Table 5:County by County Analysis of Funding for Prevention/Treatment

		Current		Current		Current	
	Census	Federal	Current	Federal	Current	Federal	
SUMMARY	2000	and State	Prevention	and State	Outpatient	and State	
BY COUNTY	Population	Prevention	Per Capita	Outpatient	Per Capita	Residential	
Albany	32,014	\$58,082	\$1.81	\$136,185	\$4.25		
Big Horn	11,461	\$14,674	\$1.28	\$43,049	\$3.76		
Campbell	33,698	\$36,294	\$1.08	\$101,656	\$3.02		
Carbon	15,639	\$28,455	\$1.82	\$64,622	\$4.13		
Converse	12,052	\$18,817	\$1.56	\$54,255	\$4.50		
Crook	5,887	\$7,449	\$1.27	\$21,291	\$3.62		
Goshen	12,538	\$11,915	\$0.95	\$27,935	\$2.23		
Fremont	35,804	\$48,207	\$1.35	\$111,227	\$3.11	\$200,750	
<b>Hot Springs</b>	4,882	\$6,921	\$1.42	\$20,000	\$4.10		
Johnson	7,075	\$8,595	\$1.21	\$24,566	\$3.47		
Laramie	81,607	\$71,485	\$0.88	\$370,704	\$4.54	\$551,150	
Lincoln	14,573	\$14,517	\$1.00	\$49,009	\$3.36		
Natrona	66,533	\$95,448	\$1.43	\$223,927	\$3.37	\$654,080	
Niobrara	2,407	\$3,854	\$1.60	\$11,113	\$4.62		
Park	25,786	\$24,601	\$0.95	\$76,148	\$2.95		
Platte	8,807	\$7,446	\$0.85	\$17,460	\$1.98		
Sheridan	26,560	\$33,235	\$1.25	\$94,991	\$3.58	\$551,150	
Sweetwater	37,613	\$50,130	\$1.33	\$136,283	\$3.62	\$350,400	
Sublette	5,920	\$5,116	\$0.86	\$20,000	\$3.38		
Teton	18,251	\$12,241	\$0.67	\$39,533	\$2.17		
Uinta	19,742	\$17,760	\$0.90	\$61,462	\$3.11		
Washakie	8,289	\$11,450	\$1.38	\$37,591	\$4.54		
Weston	6,644	\$8,022	\$1.21	\$22,929	\$3.45		
	493,782	\$594,714	\$1.20	\$1,765,936	\$3.58	\$2,307,530	
Command Found	 						
Current Fund	State Prevent	ion	\$378,773	Total State	\$3,623,935	_	
	Federal Prevention			Total Federal			
	State Outpatient			1 313 3 3 3 1 4 1	\$4,668,180		
	Federal Outpatient				ψ+,000,100		
State Residential			\$112,624 \$1,591,850				
	Federal Residential						
		Total					
			\$4,668,180				
	-				+	-	

Wyoming service providers have done well with what little they have been given. With insufficient funding, they have developed a statewide delivery system. In the latest fiscal year, their programs have served nearly 7500 people. For many of these people, no other services are available because of their low income. One-third has an annual income of \$10,000 or less and the income of 55% is below \$20,000. The mental health and substance abuse centers deserve to be applauded for doing so much with so little. What they are able to do is supplemented by services from a variety of private sector providers, community corrections facilities, and facilities such as Cathedral Home in Laramie and St. Joseph's in Torrington. While all of these providers struggle to help those in need, inadequate funding, nevertheless, begets an inadequate system. The result is a disconnected, multi-layered system of service delivery. There are no unifying standards. One of the primary goals of this plan is to create a unified system.

Despite these commendable efforts there are many more people who need treatment for whom the current system fails to provide an open door. It is estimated that there are currently more than 30,000 Wyoming men and women in need of treatment for addictions to alcohol and other drugs. 169

The waiting lists are long. Lengthy waiting lists pose a huge, unacceptable barrier to effective treatment. For the most part, addicts do not plan for

treatment. Events take over. A spouse demands they get treatment or get out. An employer lays down an ultimatum. A health crisis gets their attention. Whatever the primary motivation, there may arrive a moment in time when motivation is so high the addict shows up at the treatment facility. If he or she is told, "We can help you...in a month or two," it is likely the motivation will be long faded away before his or her name surfaces to the top of the waiting list.

Nearly everyone involved in the system recognizes it is not meeting the need. There are considerable gaps in treatment and prevention efforts precluding many from receiving the treatment they need to successfully remain in recovery. A recent report from the U.S. Department of Health and Human Services summarized what the Department found to be the characteristics of an inadequate treatment system. The key problematic characteristics are:

- ⇒ Treatment planning that is programbased rather than client-centered;
- ⇒ Inconsistent use and application of available tools to match client needs to a treatment plan;
- ⇒ Insufficient financial resources. 170

Each of these inadequacies is present in Wyoming's service delivery system. Funding limitations severely restrict the ability of the system to provide adequate residential and intensive outpatient programs. While all centers offer outpatient care, only a handful provides *intensive* outpatient care, which should be the mainstay of an effective delivery system.<sup>171</sup>

A comprehensive system of care would begin by evaluating the needs of the client and have the ability to refer them to treatment that would meet those needs. Inadequately funded systems operate differently. They do not evaluate the necessary level of services because that would be a costly, academic exercise. Clients are generally placed in whatever program may exist because that is all there is, not necessarily because of a high level of confidence the program will meet the client's needs. The chart below a general picture of the programs in state-funded, substance abuse centers. One can readily see the gaps.

Wyoming's system is programoriented rather than client-based. Not only are there few intensive outpatient programs, there are fewer women's programs - despite clear research showing that women, particularly women with children, require considerably different addiction treatment services than do men. There are no culturally specific programs outside the Wind River Reservation.

There are no system-wide treatment standards or means of determining priorities. There are no agreed-upon quality control or program evaluation systems. Data collection is inconsistent, rendering the data confusing and unhelpful in many instances. If Wyoming is serious about meeting the challenge of substance abuse, we must commit ourselves to investing in the creation of a comprehensive treatment system.

# Describing a comprehensive system

The term "addiction" cannot be relied on to describe the impact of substance abuse on all abusers. The impact varies. Its impact depends on the person, his or her personal characteristics, environment, genetic makeup, and other factors including, of course, the addict's drug of choice. It follows logically that a comprehensive system must take those variables into account. For example, treating a male heroin addict or alcoholic who is being released from prison poses significantly different challenges from the treatment program required for a young mother who is addicted to methamphetamine or an elderly patient addicted to pain killers.

Failing to recognize and meet the varied needs dooms any program to limited success, at best. Treatment, however, can be successfully accomplished in a variety of settings. "Variety" is the operative word. The treatment modality may vary from person to person, as will the length of time required. But, policymakers can be assured that when treatment is done well in the context of a comprehensive system, the likelihood of success increases significantly. Then the investment we make will produce the intended result.

"The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient." 172

The National Institute on Drug Abuse, one of the nation's leading sources for reliable science-based addiction research, concludes that the components of a

comprehensive drug abuse treatment system include a client- specific treatment plan developed after intake processing and assessments and supported closely by behavior therapy and counseling, substance abuse monitoring, self help and peer support groups, pharmacotherapy, continuing care, and clinical case management.

Figure 41 Directory of Substance Abuse Services

	Addiction Severity	Urinalysis			Intonelvo	Residential	Youth	West	Welt List	Residential	Adult	Welt	Welt List	Hellway	Hospital	CARF
Provisier	Index (ASI)	Yeating	Detox	Outpatient	Outpatient	Youth	Seds	Liet?	Management:	Adult	Bede	List?	Management	House	inputient	Certified
) Big Hom County Counseling				x												
Campbell County Memorial Hospita	ı		x	x	х										x	
Carbon County Counseling Center				x												
) Central WY Counseling Center	x	x		x		x	8	X	X	х	13	X	X			
Curran-Seeley Foundation		x		x	х											
Eastern Wyoming Mental Health Ce	inter	x		x												
) Fremont Counseling Service		x		x	x											
) Hot Springs County Counseling	x			x												
Lincoln County Mental Health Assn.				x	x											
0) Mercer House-Casper				x												
Mountain Regional Services Inc. Comerstone Behavioral Health)		x		x	x											x
2) Northern WY Mental Health Cente	,			x												
3) Pathfinder		x		x	х											
4) Sho-Rap Alcohol Rehabilitation Co	onter									x	10	ж	1ST COME/SCROON	x		
5) Southeast WY Mental Health Cen	x	x	x	x						x	12	×	×	x		
6) Southwest Counseling Services	x	x		x	х					x	39	ж	x			x
7) Sublette Community Counseling S	ervices	x		x												
8) WYSTAR (Sheridan House)	x	x		x	х					x	70	×	×	x		x
19) Washakie Mental Health Services		x														
0) West Park Hospital District (Ceda)	x	x	x	×	x	x			1st come	x	14		1st come		x	

The elements of case management require that other needs of the addict also be met. These needs vary widely but

among others can be laid in large measure at the feet of an inadequate addictions treatment system. Nationally,

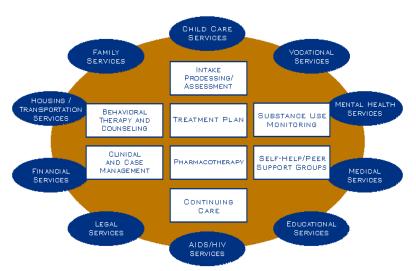


Figure 42: Comprehensive Substance Abuse Services

usually include mental health, legal and health services, education, employment, and vocational, housing, financial, child care, and family services, among others. While it may seem to be financially expedient to short-change some or all of these elements, the fact is that it is "penny wise and pound foolish" to do so. Substance abuse treatment is not a program that produces a proportionate result. That is to say, making a 50% investment does not assure you of a 50% return. Short- changing the programs usually produces a far smaller result. At times, it even worsens the situation. Put simply, there are elements of a treatment program that, in their absence, render success unlikely or impossible.

Effective treatment reduces costs and avoids substantial expenditures. The huge cost increases Wyoming has experienced in child welfare, corrections, and special education,

it is estimated that more than 75% of those who need treatment do not get it. <sup>174</sup> In Wyoming that number is closer to 90%! <sup>175</sup> These numbers stand against statistics that demonstrate that good addictions treatment saves considerable public and private resources.

Consider these numbers: a Center for Substance Abuse Treatment study concluded that one year following treatment, 40% of women addicts had reduced or eliminated entirely their reliance on welfare, <sup>176</sup> effective treatment reduces alcohol and other drug use and thus criminal activity by 40% to 60% among offenders, <sup>177</sup> the benefits of treatment outweighed the costs by a ratio of 4:1 in one California study. <sup>178</sup>

While the studies are unanimous in supporting treatment as crucial, the dilemma is found in creating and funding a comprehensive system. The

National Institute on Drug Abuse (NIDA) has published an important guide establishing research-based principles for addiction treatment. The diagram below depicts NIDA's recommendations for a comprehensive system.

#### The Gaps

Using the NIDA recommendations as a standard for delivering effective, comprehensive services, the gaps in the current Wyoming delivery system are glaring. Providers use inconsistent tools at intake resulting in a wide disparity of data collection. Few providers use research based tools such as the Addiction Severity Index to assess the client. Fewer still use appropriate tools such as the ASAM to determine the level of services required of the individual. Delivering effective services requires the intake process to result in reliable information.

While there is a paucity of residential capacity, perhaps a greater gap is the fact that there are far too few intensive outpatient programs. Those that do exist are inconsistent in the numbers of contact hours and fail frequently to provide the service when most needed, i.e. weekends.

Transitional services and case management are absent from many programs. One on one counseling is used disproportionately when stronger emphasis on group therapy and therapeutic community concepts would produce a more consistently successful outcome. Drug and alcohol testing is

absent in many programs and where done, it is inconsistent and frequently fails to use effective protocols. The programs generally do not have enough access to pharmacological alternatives.

Filling the gaps is important to establishing an effective treatment system. Not all communities will be able to provide the full continuum of services and no one provider will be able to do so. Nor should they. Creating a comprehensive system should be the result of the broad integration of services. Many of the elements currently exist and if a community collaborates it will be able to piece together an effective system. In the process of collaboration, a community will be able to identify and avoid duplication while recognizing and filling any gaps.

There is one gap that must be filled at the state level. The most significant gap is the virtual absence of **treatment standards**. The legislature should authorize the promulgation of standards that must be followed by both private and public treatment providers in order to create not only a comprehensive system, but an accountable one!

#### **Treatment Plan**

At the center of any comprehensive system is the treatment plan. In order to develop a client-specific treatment plan, the therapist needs to conduct an addiction evaluation and assess the level of services that person may require. It is important that this information is collected and that it be collected uniformly throughout the system. The

quality of the care provided is contingent on the quality of the information gathered during the assessment. As clients move throughout the system, it is useful that different programs and therapists talk the same language. It is also critical to a meaningful analysis of the individual's progress as well as the evaluations of the system that this information be collected the same way regardless of the program administering the evaluation.

We recommend that the Legislature instruct the Departments of Corrections, Family Services, Education, and the Department of Health to jointly promulgate rules designating researchbased evaluation tools that will be used in all programs funded by the state or to which courts refer patients for addiction treatment services. These instruments should be used to evaluate the severity of the person's addiction and to determine a recommended level of services. The provider should be required to use this information in developing a client specific treatment plan.

#### **Treatment Standards**

While the availability of services may vary from one community to another, the quality should not.

Whatever services are provided must be delivered at a high level of quality if taxpayers are going to receive a good return on their investment. It is recommended that the Legislature authorize the establishment of research-based treatment standards. It is critical that the standards adopted be specifically

applicable to Wyoming. There are differences to delivering substance abuse services in a rural state that must be recognized. Cultural differences must be honored. The standards must make sense in the context of the people, resources and special needs of our state. 179

All state-funded providers and any other program to which a court may refer a person should be required to adhere to those standards. Standards should address not only the quality of the treatment programs but also make certain that high-priority populations are receiving treatment, and that when waiting lists are necessary, people on them are receiving appropriate interventions.

Addiction treatment is a matter of significant interest to four large state agencies: the Departments of Health, Corrections, Family Services, and Education, It is recommended that the Legislature require treatment standards be determined jointly by these agencies, and that they be promulgated no later than September 30, 2002.

The Department of Health should be given the responsibility for certifying program compliance with the standards. It should further investigate the option of contracting with a private entity for quality assurance and accountability, including eligibility determination, authorizing services, case tracking, utilization reviews, enforcing state standards, and measuring outcomes. The state of Idaho contracts with a private firm for these services at a cost of about 10% of the funds appropriated for treatment services. A third party contract

is probably preferable to increasing the number of positions in the Department to provide this critical service.

#### Case Management

The rural nature of Wyoming poses special challenges to the delivery of effective substance abuse services. with small communities and great separating distances, it is clear that there is a greater need to provide good case management as a part of delivering treatment.

Definition: Case Management A method of providing services whereby the professional assesses the needs of the client and the client's family and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs.<sup>180</sup>

In the absence of effective case management, the investment Wyoming makes in treatment will produce significantly limited returns. The length of time a person remains engaged in treatment is the best predictor of success. Good case management has proved to be a strong motivator for keeping the addicted person engaged in his or her treatment program.

"Treatment may be more likely to succeed when a client's other problems are addressed concurrently with substance abuse. 181

Case management can be viewed as having five basic functions:

- ⇒ identification of the client's needs (and strengths),
- ⇒ assessment of those needs (and strengths),
- ⇒ service and treatment planning,
- ⇒ linking and referring clients to proper resources, and
- ⇒ monitoring cases to insure that services are not only used, but used properly. 182

At current funding levels of an average of \$3.58 per capita, effective case management can not be expected. One of the first casualties of an underfunded treatment system is case management. It is true that even now some form of "case management" usually occurs, but on a limited, disconnected basis. Referrals may be made to other services. Therapists try to connect clients with housing, educational, medical or other services. But if the taxpayers are going to invest in good therapeutic interventions, failing to follow-up in an intentional and methodical manner frequently negates that investment.

This is where we must recall the metaphor of the New York subway cars. If, for example, we spend thousands of dollars providing treatment at an ITU in one of the prisons but fail to spend a few more bucks making certain the inmate has a smooth re-entry into the community, we have failed to protect

both the public safety and the public investment. Case management oftentimes makes the difference between long-term success and early relapse and recidivism. If an inmate leaves the ITU and is monitored and assisted as he or she returns, so that adequate housing is provided, job assistance given, medical needs coordinated, and other needs recognized, we will realize a much greater return on our investment. Once we "reclaim" a person, it only makes good sense to commit the necessary resources to make certain he or she remains "reclaimed."

Many of the services clients require currently exist in most communities or, with some coordination, can be identified and used. The problem is that they are fragmented. Some are public, others private. Most are offered through programs that are governed by separate boards or management. There is little communication and collaboration among these providers. The little that takes place is not institutionalized. One of the chief goals of this plan is to create the mechanism to integrate these services, so that in any given community there is a common goal of working together so that substance abusers get good wraparound care. If that can be accomplished, the success of drug and alcohol treatment will climb significantly.

### Creating a Unified Treatment System

It should be noted here that during the course of the study we received suggestions from several quarters that all substance abuse treatment funds be made available on a competitive basis where existing community mental health and substance abuse centers would receive no priority or preference. The argument that competition would be healthy and reinvigorate the system is appealing. However, it may ignore the reality of Wyoming which includes the fact that while such competitive forces may exist in larger communities, they do not exist in many smaller communities. We also believe that unless the system is anchored with community substance abuse center participation, chaos would result from periodic competitive bidding for these basic services. However, that does not mean a system should be built that does not include significant competitive forces.

As an alternative, we support creating a unified treatment system that permits competition while continuing to support the existing infrastructure. The system would include the mental health and substance abuse centers as well as other public and private providers in an integrated delivery system unified around common standards.

The state has invested considerable dollars and years in the development of a community system. As we move toward a unified treatment system, it will be essential that one community-based agency take the lead in integrating services. A unified system does not mean there should be only one provider. It means that all players are integrated so that people in need receive *high quality services*, that *services are client-based* rather than program-based and that, to

the extent possible, *the dollar follows the client*. We are persuaded the existing substance abuse centers can effectively serve as the hub for integrating and unifying a comprehensive delivery system. Only where they are unable to do so, should alternatives be considered.

Additionally, these centers already provide the important mental health services that must be coupled with other services provided to virtually all substance abuse clients. The ability to provide for the mental health needs of addicts during the course of addiction treatment mitigates toward strengthening, not weakening the existing structure. We do not believe it should be endangered by these reforms.

We do believe the centers should be encouraged to improve the services they offer. If, as some of the critics of the system contend, the centers have failed in some cases to provide quality services, the responsibility lies in a failure of the state to adequately fund programs and in the failure of the state to establish and enforce clear standards. If the state is willing to take the lead, establish the standards, enforce them, and make the necessary financial investment, the need can be met. Likewise, we believe the community centers are not able to meet the need alone. There are other providers in the public and private sector that must be a part of a unified system of care.

Therefore, we recommend significant increases in the funding for the existing centers with funding tied to the accountability measures outlined

herein. The state should establish standards for treatment and integration of services. Funding decisions should be employed to make certain that services are in fact integrated, treatment standards met, and that priority populations are receiving adequate services. Where those goals cannot be met, alternative providers should be sought. Allowing adequate time for the establishment of standards and for programs to meet them, the Legislature should mandate that from and after July 1, 2003, funding be denied to programs that are unable to comply.

At the same time, there is a need to create additional funding streams to assure the need is met with quality services. The certification of providers who meet state standards will mean that additional providers can receive Medicaid payments for services to those who qualify. Bringing additional dollars into the treatment system through Medicaid makes good policy and fiscal sense. Whereas treatment provided by general funds costs the state 100%, treatment purchased by Medicaid dollars costs the state only about 35 cents on the dollar with the federal government paying the remainder.

Additionally, we are recommending that substance abuse treatment dollars be included in the budgets of the Department of Family Services, Department of Education, and the Department of Corrections. These dollars should be used by those agencies to purchase treatment services to meet the unique needs of their clients on a competitive basis from providers that are

certified for the services sought. This will provide additional incentives to the community centers and other providers including the private corrections firms to upgrade the quality of their programs. The playing field will be leveled and a unified system created by requiring all programs that receive state dollars as well as those to whom courts refer people to comply with state treatment and certification standards.

#### A Tiered Delivery System

Given the geography and the demographics of Wyoming, it is clear that not all communities will be able to provide services at the same level. Yet, it is equally clear that all services necessary need be made available as may be required of the target populations. Therefore, we recommend the creation of a tiered delivery system using primarily the existing community mental health and substance abuse centers as the hub for integrating community services and resources.

#### Tier One

On any given day, there are approximately 4500 people on probation and parole in Wyoming. Over 60% of these folks reside in just 6 counties. Those counties are Laramie, Natrona, Sweetwater, Campbell, Fremont, and Sheridan. The vast majority of these men and women have substance abuse problems. Many of them fail while on probation and are sentenced to prison terms as a result of continued, compulsive drug and/or alcohol abuse. We recommend these people and,

therefore, these counties be targeted for the highest level of services.

Targeting these probationers/parolees makes sense in terms of protecting public safety as well as in reducing the costs of imprisonment. These are people who have already committed crimes. The judge has determined their crime did not warrant the people spending over \$22,000 a year to house them at one of the prisons. But, when they have a substance abuse problem, the likelihood is very high they will fail, their probation will be revoked, and they will land in prison.

In 1998, forty-two per cent of the Wyoming prison population increase resulted from probation revocations. A whopping 70% of those resulted from substance abuse!

When a district judge orders probation revoked and the defendant sent to prison, he or she is, in effect, appropriating more than \$22,000 a year to care for that person. Many of those costs can be averted if Wyoming does a better job of providing substance abuse treatment and other related services to probationers.

Another reason to target this population is that we know who they are, we know when they need treatment, we know where they are, and we are able to exercise sufficient control over their lives to force them into treatment and keep them there long enough to achieve a good result in most cases. In addition,

the state may require those who might choose to reside where services are inadequate to meet their needs to live, instead, in a C-SAC community. (See the section on the effectiveness of coerced treatment)

The proposal is that these six counties will be the sites of Comprehensive Substance Abuse Centers (C-SAC's). The C-SAC's will provide the most comprehensive set of services available in the state. These centers will provide directly or through referrals the full continuum of services from detoxification and long-term residential care to intensive outpatient, traditional outpatient, case management, and continuing care. More importantly, the C-SAC's will be required to serve as the hub agency in their community integrating and coordinating the services offered by all other public and private agencies and programs. They will not be asked or permitted to do it all, but they will be the catalyst to make certain it is all available and operated effectively. This will require the C-SAC's to bring the other players to the table including the Department of Corrections, private corrections providers, private substance abuse providers, DFS, the local court system, the schools, the faith community and other members of the private sector, the hospital, jail, the recovering community, and any other interested party. Collaboration among providers is absolutely critical, but it does not just happen. If a system is to achieve the necessary degree of collaboration, it must be institutionalized. It is hoped that by assigning this role to the substance abuse centers and funding this role, we

will be able to institutionalize the kind of collaboration necessary to integrate community programs and resources effectively.

While these comprehensive programs will provide much needed care for probationers, they will in that process also become more effective treatment providers for other target populations such as adolescents, women of child bearing age, and others. The target population will be determined by community demographics. The Substance Abuse Division contracts with the centers will allocate treatment dollars to meet the priority needs. While the nature of the substance abuse problem may vary from community to community, the C-SAC's and the Division will be responsible for assessing the need with good data and meeting that need directly or through other available programs and services.

The Legislature should direct that all other funds received through state and federal grants for community substance abuse related programs be coordinated with the C-SAC's so that all community players are required to collaborate and coordinate, using state-of-the-art and research-based programs.

#### Tier Two

The second tier will be composed of those counties that are able to provide all C-SAC services except residential care. The state should not encourage the development of costly residential care facilities in more than the six first tier counties. Counties in the second tier will

be encouraged to integrate with larger counties to refer those who need residential care. Like the C-SAC's, these centers will be the hub agency responsible for integrating and coordinating services.

#### Tier Three

There may be a handful of counties with insufficient resources to meet the requirements of tiers one or two. These counties, when granted a waiver, will constitute the third tier, and will be required to provide limited services at a high level of quality. They will also be required to develop referral or other relationships with larger counties so that clients may be provided an appropriate level of services regardless of the limitations of that particular center.

#### **Priority Populations**

One of the recurring concerns raised by people and agencies during this study was that there is no clear definition of priorities. Regardless of funding levels, we cannot provide all services to all who are in need. The system has in many ways attempted to do that and the result has been a dilution of services. Diluted substance abuse services have typically unacceptable failure rates.

We conclude there is a need to provide the system with some direction about which groups or populations of substance abusers are priorities for limited resources. In making this recommendation, we are mindful of the success of drug courts nationally and in Wyoming. Their success stands in

marked contrast with the failure rates of many programs. The reason has to do largely with the ability of the criminal justice system to coerce participants into treatment *and* to keep them there long enough to make a difference.

Their success stems equally from the fact that they take whatever resources they have, e.g. money, treatment capacity, monitoring and supervision, etc., and apply them to a limited number of addicts. They screen and admit a particular, targeted population and then they give them all of the services they require to get into recovery. That is what works, not only in drug courts but also in treatment across the board.

We recommend the Legislature and other policymakers give attention to these factors. The *coupling of coercion* with sufficient resources can reasonably be expected to produce considerably higher success rates than otherwise. In the final analysis that means priority must be given to those persons over whom the system can exercise some degree of coercive power. The combined elements of this plan provide the means of establishing priorities largely built around not only the need for services, but also defining populations where we have the opportunity to exercise some meaningful degree of control that will permit holding substance abusers accountable.

The authors of this report recognize this idea flies in the face of a commonly held myth that teaches addicts cannot succeed in treatment unless they really want it. It is critical to reforming the system that this myth be discarded and

replaced with an assertive commitment based on the idea that we all have an interest in providing treatment for substance abuser and when we do so, we need to take the steps reasonably necessary to raise the likelihood of success. The authors also recognize that some may not like the term "coercion." Regardless of the term used, the system must employ a mechanism that permits it to not only engage addicts in treatment but also retains them long enough for the treatment to work. Engaging them without retaining them wastes valuable resources. A system that relies on the addict's voluntary willingness to stay in a program will not justify the investment of public funds and cannot hold users accountable.

#### The Case for Coercion

The title of this subsection comes from an article written by Dr. Sally L. Satel and published in the Winter 2000 edition of the *National Drug Court Institute Review*. Dr. Satel is a practicing psychiatrist and lecturer at Yale University. She is also an adjunct scholar at the American Enterprise Institute. Dr. Satel is the sort of person to whom those who are serious about investing in treatment should listen.

One of the most damaging myths in the debate over substance abuse treatment is the one that says, "A person really has to want it before it will work." Untrue, says Dr. Satel and many others. It is a myth that makes no sense when you begin to understand the real nature of addiction.

"A massive amount of data, assessing roughly 700,000 patients since 1967, emerged with two clear findings. First, the length of time a patient spends in treatment is a reliable predictor of his or her posttreatment performance. Beyond a 90 day threshold, treatment outcomes improved in direct relationship to the length of time spent in treatment., with one year generally found to be the minimum effective duration of treatment. The second major finding was that coerced patients tended to stay in treatment longer."183

Studies demonstrate that those who enter treatment voluntarily are few. Of them, most will leave early...too early for the treatment to have been effective. "For these early drop-outs, the benefits of treatment disappeared within the year. "184 Dr. Satel acknowledges that some argue coercion is not the key so much as matching the patient with proper treatment. This argument holds that motivational treatment is sufficient to hold the client to an effective duration. Clearly this is an important element of successful treatment, but Dr. Satel's article cites authoritative research that shows that those most likely to remain in treatment sufficient lengths of time are those who were coerced

"At the American Society of Addictions Medicine's annual conference in 1998, Dr. Norman S. Miller, associate professor of psychiatry and neurology at the University of Illinois, Chicago, declared, 'Coerced treatment is effective in a broad array of

people and it should be adopted as policy.' And John Carnevale, director of Programs, Budget, Research, and Evaluation at the White House Office of National Drug Policy, notes that his agency 'embraces the idea of using coerced treatment because it gets people into treatment." We support coerced treatment because it not only gets people into treatment. More importantly, it keeps them there long enough for treatment to work.

The court is an effective coercion agent, but it is not the only one. A serious challenge to addiction means being willing to act early. It is in the interest of public safety not only to hold users accountable, but to do so, whenever possible, before they commit crimes. Indeed, one important goal is to tend to people's substance abuse problems early, before they get into the criminal justice system. If we are going to open more doors to treatment and increase the success rates, the treatment system must develop other useful means of coercing addicts. Some other possibilities include:

- ⇒ Employee assistance programs where employers are encouraged to identify and confront employees with substance abuse problems and give them a choice between losing their job and entering treatment,
- ⇒ Adoption of policies by state licensing boards that give professionals a choice between losing their professional license and getting treatment,

- ⇒ Replacing so-called "zero tolerance" policies in schools with policies that encourage the identification of atrisk kids early so that they can be required to get the help they need as a condition of remaining in school,
- ⇒ Including needed substance abuse treatment in the case management of those who apply for other state benefits such as employment, day care, vocational rehabilitation, etc.,
- ⇒ Child protection rules that require successful and continuing treatment to be an integral part of the decision accomplish family re-unification,
- ⇒ DUI court practices that adequately supervise offenders to make certain that return and retention of a drivers license is tied to continuing treatment.
- ⇒ Involuntary commitments of people who are proved to be a danger to themselves or others or unable to care for their dependents because of abuse of alcohol and other drugs.
- ⇒ The successful use of coercion requires more than a judge's order that a defendant not use or the requirement of the employer or caseworker that a person stop drinking or using drugs. If coercion is to work in a way that results in successful treatment, an intentional program must be developed that includes effective and motivational treatment, measured and graduated sanctions, as well as supervision and monitoring. Accountability is a two way street. The addict is held

accountable only if the system is also accountable. Each plays an important role in the addict's successful recovery.

One of the key goals to be realized by upgrading the treatment delivery system is to make drug and alcohol abusers accountable by making certain that effective treatment is available to schools when they identify a student at risk, to employers when they have a worker who needs help, to families when a loved one is ready. It makes no sense to wait until they commit a crime when all of these systems have the ability to coerce the addict into treatment earlier...but the treatment program must be available.

⇒ Accordingly, it is recommended that priority for treatment services be given to those persons over whom coercion may be exercised.
 Concurrently, the appropriate agencies of state government should be required, with the assistance of the Division, to develop rules and policies that employ reasonable coercion to cause people benefiting from their programs or otherwise under their jurisdiction to receive treatment

A new study has found that rewards such as vouchers or certificates for food or clothing or tickets to sporting or other events, are effective means of retaining participants in treatment. 186

#### Workers' Comp

For example, W.S. 27-14-201(o) already allows the Division of Workers' Compensation to write rules granting "a discount to rates...in an amount not to exceed ten percent (10%)...if the employer complies with a safety program approved by the division." This provision should be used as an incentive for employers to use effective employee assistance programs developed under guidelines established by the Substance Abuse Division. DataCorp's review of the Wyoming situation resulted in a similar recommendation.

Developing incentives, such as reduced rates for Worker's Compensation (premiums), might spur the development of consortium-based EAP's (employee assistance programs). This type of service would allow numerous companies to join together to put a referral and treatment system in place for troubled employees.

⇒ As a matter of public safety, assuring a clean and sober workforce is an important goal that can be achieved in this manner. Such a program, using coerced treatment combined with employer incentives can reduce

workers' comp claims and get people the treatment they need.

## Department of Workforce Services

- It makes little sense for the state  $\Rightarrow$ to provide job training, daycare, vocational rehabilitation, food stamps, or other assistance designed to help people to their feet if, at the time they are receiving these expensive state benefits, they are abusing or addicted to drugs and/or alcohol. A Washington State study of AFDC recipients concluded what most would think obvious. Welfare recipients who received substance abuse treatment as a part of their case management fared better than those whose substance use went unaddressed. Welfare payments to those who received treatment declined while their rates of employment rose. It is important to note though, that unless they also received employment and other services at the same time, the increase in self-sufficiency was minimal 187
- ⇒ As the new Department of
  Workforce Services (DWS) develops
  its plan, we will continue to work
  with their team to integrate these
  efforts. There is an obvious and
  important relationship between the
  development of a comprehensive
  substance abuse plan and the mission
  of DWS to "develop comprehensive
  and effective services that build a
  workforce to meet the changing
  demands of Wyoming's diverse

- businesses, citizens, and economy." <sup>188</sup>
- ⇒ We view substance abuse as a barrier to economic development and the implementation of a good, comprehensive plan to be a necessary adjunct to the important economic development efforts of the state. Businesses are composed of families. A business considering whether to relocate to our state will view our commitment to meet this challenge favorably.

Coincidentally, this plan and that of DWS are due to be submitted to the Legislature and the Governor on October 1, 2001. There have been preliminary discussions between the writers of this plan and the DWS staff focused on the idea of connecting substance abuse screening and treatment with the provision of certain state benefits. A simple and brief screening tool could be used on intake to make an initial determination as to whether or not additional substance abuse assessments are required.

⇒ If red flags are raised, the applicant should be referred for an assessment and, if necessary, treatment should become a part of the overall case plan for providing benefits. To be sure, we are not recommending that people with substance abuse problems be disqualified from receiving state benefits. Rather we propose that the receipt of benefits be made contingent on the applicant getting treatment. In this way, Wyoming sends an important

message to businesses considering locating here that we will provide them with a drug-free workforce and a safe community in which to do business and relocate their families. At the same time, we would be assuring taxpayers that the money they invest in these programs will more likely make a difference in the lives of people the programs are intended to help.

⇒ Additionally, the intake and case workers must be cross-trained on substance abuse issues, giving them a working knowledge of the signs of abuse, appropriate treatment, and how to hold abusers accountable.

## The Adoption and Safe Families Act of 1997

In November of 1997, the President signed into law the Adoption and Safe Families Act (ASFA). The act identifies key principles regarding child welfare including establishing child safety as a paramount concern of the system. The act requires foster care be only a *temporary* setting, promoting timely adoption for those children who cannot be safely returned to their homes. Finally, the law requires that "permanency planning" efforts for the child begin as soon as the child enters foster care.

ASFA focuses on results and the accountability of the child welfare system as well as the parent. The key relevant requirement of the act is that the state must file to terminate parental rights if the child has been in foster care

for 15 of the last 22 months. The act is designed to give kids some sense of permanency in their lives that can be attained only in permanent placements that mean adoptive families where birth parents cannot get their acts together. In so doing, the act creates a time limit that provides a useful opportunity to coerce or motivate successful treatment.

Parents who have alcohol or other drug problems do not drink or use because they do not love their kids. They use because they are addicts. Their need for the drug or drink overcomes their ability to care for their children.

One of the few prospective studies of children of substance abusers found that nearly all suffered some level of neglect, one-third of children whose parents abused substances suffered serious neglect. \*\*\* Children growing up in households with a substance abusing parent demonstrate more adjustment problems, behavioral, conduct, and attention deficit disorders, and generally function less well on many measures of behavioral and emotional functioning. 189

There are some other interesting facts to consider here. "Most studies report that between one-third and two-thirds of substantiated child abuse and neglect reports involve substance abuse. Substance abuse is more likely to be a factor in reports regarding younger children, particularly infants, than older children. In addition, substance abuse is more likely to be a factor in child neglect

than in child abuse."<sup>190</sup> Yet, alcohol and drug related cases are more likely than others to result in foster care placements. "Nearly a third of cases involving substance abuse resulted in foster care versus less than 20% of other cases."<sup>191</sup>

These kids grow up to have their own set of substance abuse and other problems that not only affect their lives but state and local government budgets as well. We are haunted by the question asked of us when a group from the Governor's Advisory Board on Substance Abuse met with a group of young girls at the Wyoming Girl's School. This 16 year-old girl is a meth addict, now in recovery thanks to the treatment she has received at the Girl's School. She told us of how she grew up in a home, well-known in the community for the fact that her parents were drug dealers and addicts. She had been a good student and an athlete but at some point gave in to the pressures at home and began drinking and using drugs. Her grades dropped. She was kicked off the basketball team. She was arrested over 70 times...and never taken from the home and offered treatment!

She told her story. Then she looked at us and said, "Why didn't someone come and take me out of that house? They all knew what was going on...and no one came!"

It is imperative that we devise a system that intervenes early for these kids, protecting children, while providing treatment for parents with the goal of re-unifying families. We can do so if we combine the natural love of the

addicted parent with good treatment programs. Simply informing an addicted mom at the time her child is removed from the home that she has 15 months to get into recovery is insufficient and dooms her, the child, and the system to failure. On the other hand, if these families are truly a priority, a partnership between treatment providers, the child welfare workers, and the courts can result in effective efforts to introduce the parent to treatment, engage and retain him or her, and reunify the family as other necessary, supportive services are provided.

An example of such a program is "Options for Recovery", a Sacramento, California program that reaches out to these families rather than waiting for them to come to the providers' doors. Substance abuse workers are present in the courtroom when the judge removes the child and places her in foster care, to take the parent, at that traumatic moment, into treatment. That is a critical moment. The opportunity is frequently missed when the parent is simply told, "You must get treatment and here is a phone number for you to call." This program uses "outreach/engagement teams" that make home visits. encouraging reluctant participants. They provide on-site child-care recognizing that those participants who have children at home need this kind of support if they are to attend treatment groups. They provide means of transportation when simply "getting there" is a barrier. They cross train child welfare workers and substance abuse personnel so that their efforts compliment rather than conflict.

We know and have the responsibility to deal with the fact that addicts do not make good choices particularly in the early stages of treatment. They frequently lack necessary resources to participate in treatment. Many have lost their driver's licenses. Some do not own a vehicle. All have auxiliary needs that must be met if *our* investment is to pay off. In short, if their recovery and their reunification with children is a priority, the system must act differently.

One recent study demonstrates why reunifying these families is critical to the future. In a national survey conducted by Parents' Resource Institute for Drug Education (PRIDE), it was learned that nearly 40% of kids living in a single-father home used alcohol and/or other drugs compared to nearly 30% of those kids living in single-mother homes. The number dropped to 20% for kids living with both parents. 192 Strengthening families must be the goal of any Wyoming substance abuse plan. These kids and their parents are a priority.

Where the system seriously identifies these families as a priority, the programs will develop means of outreach to bring the moms and dads and kids in, identify their specific needs and offer wraparound services to meet them, motivating parents to stay in the program. These programs use the coercive force of the federal law, i.e. the statutory deadlines, to say, "If you want your kids back, this is what you must do and this is the time frame in which you must do it." They do not, however, simply say that. The program itself must be accountable to engage and retain the

person who needs the treatment. This is one of the first principles of *all* effective substance abuse treatment.

The standards for treatment under this plan will take these families into account and encourage meaningful partnerships between DFS, the courts, and treatment providers that strengthen families and break the cycle of substance abuse that is furthered when parents do not receive effective treatment.

There is little question that as these families become priorities and programs move to meet their needs, they will undoubtedly impact those other families where kids live with substance abusing parents who do not come into the child welfare system. This is crucial because in truth only a small percentage of kids who live with abusing parents come to the attention of this system. <sup>193</sup>

"Often a family crisis, such as a child protective services intervention, is the catalyst needed to prompt a substance abusing parent to seek treatment. The resolve of an addicted person is often short-lived, however, and unless treatment is promptly available, the opportunity for intervention may be lost. \*\*\* In addition to the general problem of treatment availability, programs addressing parents' needs are in particular shortage. Parents, and in particular mothers, have specific needs in treatment that most programs do not address....These needs include child care, services to address parenting stress, economic and educational issues, reproductive health care services, psychological services, domestic violence, and more. These services are generally not applicable to male substance abuse treatment clients, but are essential to effective women's services.194

#### **Schools**

While there are those who protest  $\Rightarrow$ that schools are being asked to do more, the fact is that our children spend more of their waking hours in schools than with parents or elsewhere. Teachers frequently witness troublesome behaviors earlier than do parents. With studies showing that as many as four of ten Wyoming high school students use and abuse drugs and alcohol, the impact on the ability of young people to receive a quality education is significant. The schools must be a major player, whether we like it or not.

The National Center on Addiction and Substance Abuse (CASA), one of the national experts consulting on this study, has recently released a landmark study on the role of the nation's schools in substance abuse. The study, entitled *Malignant Neglect: Substance Abuse and America's Schools*, was released in September 2001. The 117 page report is a must read for educators, legislators, parents and others concerned about this issue.

"Two overreaching findings of years of CASA research have prompted this intensive examination of substance abuse and the nation's schools: an individual who gets through age 21 without smoking, using drugs or abusing alcohol is virtually certain never to do so, and next to parents, the schools (the entire school environment) have the greatest influence on children." 196

The authors of this report regret that the entire CASA study cannot be reprinted here but strongly encourage that it be read. The study dramatically outlines the "profound and destructive implications" student use of alcohol and other drugs including the impact on academic achievement and the rise in delinquency. It identifies what it calls "Interventions that miss the mark" to include DARE and zero tolerance policies which "mandate predetermined consequences or punishments for substance possession or use-suspension, expulsion or referral to an alternative school."

CASA recommends all teachers, administrators, coaches, counselors and other staff be trained to recognize substance abuse early and be given the community tools to respond effectively. Drug testing should be required of students AND staff when substance abuse is suspected.

Community partnerships must be developed that provide troubled students or staff with the necessary counseling and/or treatment. High risk students should be intentionally targeted for early interventions.

Perhaps the greatest sign of the "malignant neglect" of this issue in the schools is demonstrated in polls that show that "remarkable differences exist between student's and school personnel's perceptions of student drug use. Principals provide the lowest estimates of student drug use, followed by teachers and then students. Only 19 percent of principals reported that

students smoke on school grounds compared to 43 percent of teachers and 69 percent of the students. While only five percent of principals reported that students drink on school grounds, 28 percent of teachers and 33 percent of students report that drinking occurs at school.

"When asked in 1998 if their schools were drug free, only 11 percent of principals said they were not, compared to 35 percent of teachers and 66 percent of the students." <sup>197</sup>

This disparity is not only dramatic, but is also quite troubling. It means that either, those with oversight responsibilities fail to observe or ignore clear signs of substance abuse OR that the students are have an exaggerated sense of how much substance abuse is actually occurring. Either conclusion poses the same problem. Either conclusion itself does result in higher use rates.

Wyoming schools should be encouraged to develop policies that are designed for early intervention in the lives of young people who are beginning to experiment with alcohol and/or other drugs. Prevention programs alone are not sufficient for all young people. Many schools have adopted a so-called "zero tolerance" policy that requires students who use to be expelled. According to a study conducted by the Indiana Education Policy Center entitled "Zero Tolerance, Zero Evidence: An Analysis of School Disciplinary Practice" there is no credible evidence that removing kids from school improves safety. In fact, the

study concludes, such removal results in significant negative impacts for both the school and the student. It also negatively impacts the family and the community. "Zero tolerance is a political response, not an educationally sound policy," according to the study.

- During the course of this study, we visited a school in Ft. Collins. Colorado, that has reformed its policy so that it is now designed to identify troubled kids early. Students suspected of using are tested and positive tests result in the student and his family being given a choice between remaining in school and getting treatment. Most opt for treatment and nearly all of them have successfully completed programs, graduating clean and sober. This approach holds great promise to intervene early and effectively, but it presupposes that the state will commit to a major enhancement of the treatment system. The Colorado program only works if kids can be referred to quality treatment.
- ⇒ Natrona County School District
  #1 employs a model policy. While it
  maintains the district's discretion to
  expel under egregious circumstances,
  the policy encourages the
  involvement of the student, the
  parents, and the school in getting the
  young person the professional help
  that is appropriate. A survey of the
  policies of all Wyoming school
  districts is attached as an
  Appendix.

We heard numerous concerns from educators who fear being sued for making treatment referral. We believe the legislature should immunize teachers from such threats, and that educators should further be immunized against lawsuits based on reporting students who are displaying symptoms of substance abuse.

#### **Professional Licensing Boards**

Another important opportunity to motivate substance abusers to enter treatment and to remain engaged long enough lies in the fact that the state of Wyoming issues professional licenses to tens of thousands of people allowing them the privilege of practicing their profession. The legislature has made a decision that a license to practice the profession is a necessary prerequisite because the work these people do has a direct impact on the lives and well-being of those they serve. Accordingly, it is reasonable to conclude that the state has an interest in making certain that those it licenses are not impaired by abuse of drugs or alcohol.

Every licensing board should be required to adopt rules that require impaired professionals to obtain

Table 6: Wyoming Licensing Board Survey

treatment when their abuse of substances affects their ability to fulfill the duties they have been licensed to perform.

Some boards have already recognized the importance of doing so. Some have not. The following is a summary of our review of licensing board policies.

#### **Wyoming Licensing Board Survey**

**Description of Substance Abuse Policy And available data** ff

Board

**Numbers of Licensees**ee

ee Numbers are approximate

ff Unless otherwise indicated, the reporting board has no relative data.

Architects and Landscape Architects	139 Residents 879 Non-residents	None				
Mental Health Professions Licensing Board	1095 Residents 131 Non-residents	None				
Board of Medicine	882 Residents 1307 Non-residents 91 Retired	Contract with WPAP				
Board of CPA's	561 Public practice	No specific substance abuse (SA) authority; board has 579 Non-public, General disciplinary authority, but Actions limited to censure, suspension, And/or revocation				
Board of Pharmacy	1020 Pharmacists 250 Technicians	Contracts with WPAP; does not have Specific SA rules but has general Authority to suspend license for "habitual use of controlled substances or alcohol."				
Board of Barber Examiner	rs 100	WS 33-7-311 allows suspension or Revocation of license of one whom is addicted to "liquor or drugs to the Extent that the licensee is unfit to Perform the licensed services."				
Board of Nursing Home Administrators	90	Revocation or suspension may result from "intemperate use of alcohol or controlled substances."				
Board of Occupational Therapy	213	Revocation or suspension may result from "habitual use of alcohol or a controlled substance."				
Board of Nursing Professional	4750 RN's	Contracts with Wyoming Assistance Program;				
since 1996	958 LPN's 3657 CNA's	28 RN's and 11 LPN's participated (CNA's are ineligible for WPAP services)				
Professional Teachers Standards Board	25,000	None				
Board of Professional Geologists	3200	None				
Electrical Board	5000	None. The board does not believe it has Any statutory authority to consider any Complaint against a licensee for Substance abuse.				

Board of Registration for Professional Engineers And Land Surveyors	5500 Residents 3626 Non-reside	None, however, if an "incident is ents brought to the Board's attention, we would investigate to determine if the Public safety and welfare is at risk."					
Board of Veterinary Medicine	228 residents 332 non-residents	None					
Board of Optometry 99 Residents 49 non-residents		None					
Board of Podiatry	13 residents 18 non-residents	None					
Board of Radiology Technologists Examiners	458 Residents 79 Non-residents	None					
Board of Physical Therapy	360 Residents 350 Non-residen	None nts					
Board of Insurance Agents Examiners	2765 Residents 13,702 Non-residents	None					
Board of Coroner Standards	122 Residents 48 Non-residents	None					
Board of Dental Examiners	Dentists: 266 Res 164 Non-res Hygienists: 195 Res 116 Non-res Assistants: 414 Res	None					
Board of Chiropractic Examiners	98 Residents 75 Non-residents	Revocation or suspension may result from "addiction to alcohol, narcotics, or Other habit forming drugs."					
Board of Psychology 124 Residents 47 Non-residents		If the Board has "reasonable grounds to Suspect" that a licensee or applicant "may be using controlled substances" an examination may be ordered; license can be suspended or revoked for addiction to					
Wyoming State Bar	1800	drugs, alcohol. Extensive policies for intervention					

The above professional licensing boards authorize more than 80,000 people to practice their profession. We do not believe substance abuse should automatically result in revocation of a

license. However, when it comes to the attention of a board that a person it licenses is impaired, rules should require that person to be evaluated and, where

indicated, to enter and continue treatment.

In such a way, these boards would provide important assurances to the public that the people Wyoming licenses are not impaired by substance abuse. Using such an intervention opportunity protects not only the public but also

impacts the family of the abuser. These rules should be consistent with research-based standards adopted by the Department of Health for licensing boards.

#### **Brief Treatment Interventions**

Does every case of substance abuse need months of residential or other long-term treatment? Does every case of substance abuse require intensive therapy? If this is so, the build up of services would be like Christmas in June for long-term providers in Wyoming, and potentially, nearby states.

If there are short-term or brief interventions that would reduce substance abuse, misuse, or use in Wyoming, then the state might very quickly realize benefits on its investment and allow the system to build up appropriate capacity for individuals who clearly need longer-term services. Thus, the question comes up, can we do short term, brief therapies with positive effect?

The answer is clearly, yes. Consider these examples:

#### **Brief Intervention Review**

Heavy drinking is a common health hazard among women, and appears to be so in Wyoming. While brief interventions to reduce drinking is convincing not as much evidence exists for interventions in a natural environment of routine health care.

Recently, scientists evaluated the effectiveness of long-lasting, brief alcohol intervention counseling for women in a routine general practice setting of five primary care outpatient clinics. 198 One hundred eighteen female, early-phase heavy drinkers, who consulted their general practitioners for various reasons, were given brief alcohol intervention counseling. Intervention groups A (n = 40) and B (n = 38) were offered seven and three brief intervention sessions, respectively, over a 3-yr period. The control group C (n =40) was told to reduce drinking at baseline. Main outcome measures were self-reported weekly: alcohol consumption, carbohydrate-deficient transferring, mean corpuscular volume (MCV), aspartate aminotransferase, alanine aminotransferase, and gammaglutamyltransferase. The results were encouraging. Depending on the outcome measure and the study group, clinically meaningful reduction of drinking was found in 27% to 75% of the heavy drinkers. Within all the groups, MCV significantly decreased. However, there were no statistically significant differences between study groups A, B, and C in the mean changes between the beginning and endpoint in the main

outcome measures. Conclusions: The present study indicated that minimal advice, as offered to group C, was associated with reduced drinking as much as the brief intervention, as offered to groups A and B, given over a 3-yr. period. Furthermore, in the routine setting of the general practice office, the effectiveness of the brief intervention may not be as good as in special research conditions.

In another study, scientists assessed which types of people complied to brief interventions for heavy drinking. Women and young adults were subgroups of heavy drinkers whose compliance was lower than others, and they may need more powerful brief interventions <sup>199</sup>

Brief interventions work for a significant proportion of older adults, whose population is growing in Wyoming. Consider the impact of a study tried in Wisconsin. The older adults there who received the physician intervention demonstrated a significant reduction in 7-day alcohol use, episodes of binge drinking, and frequency of excessive drinking (P less than .005) compared with the control group at 3, 6, and 12 months after the intervention. There was a 34% reduction in 7-day alcohol use, 74% reduction in mean number of binge-drinking episodes, and 62% reduction in the percentage of older adults drinking more than 21 drinks per week in the intervention group compared with the control group. The older adults received two 10- to 15-minute physician-delivered counseling sessions

that included advice, education, and contracting using a scripted workbook.

The same strategies, described above, were tested in 10 Wisconsin counties with women of childbearing age. Some 5,979 female patients ages 18 to 40 that were screened for problem drinking, 205 were randomized into an experimental group (n = 103) or control group (n = 102). The intervention consisted of two 15-minute, physiciandelivered counseling visits that included advice, education, and contracting by using a scripted workbook. As mentioned elsewhere in this document, intervention produced powerful effects. The trial reduced both 7-day alcohol use and binge drinking episodes over the 48month follow-up period (quite statistically significant). Women in the experimental group who became pregnant during the follow-up period had the most dramatic decreases in alcohol use. A statistical model revealed a 20% or greater reduction in drinking by the pregnant women in the sample exposed to physician intervention.

In an experiment with wonderful implications for Wyoming, scientists have found that a "correspondence course" cognitive-behavioral intervention can reduce problem drinking. Weekly alcohol intake fell 48% from pretreatment to 18.6 alcohol units at 12 months. The results confirmed that correspondence cognitive behavioral treatment (CBT) for alcohol abuse was accessible and effective for people with low physical dependence.

A brief intervention (15 minutes) at HMO outpatient waiting rooms found promising results on alcohol use but not medical usage over time (6 months to 2 years). This is a useful finding from a public health view and suggests that there might be ways to improve results.

Brief interventions have been successful with college-age students. At 6-week follow-ups, for example, students receiving brief intervention group show reductions on number of drinks consumed per week, number of times drinking alcohol in the past month, and frequency of binge drinking in the past month. <sup>202</sup>

Recent studies suggest that free nicotine patches with advice can help reduce smoking. A natural, prospective, open-label study tested the impact of free nicotine patches with minimal support for smoking cessation. The overall quit rate at 8-weeks was 21% (47/223).

What about drugs other than alcohol and tobacco? Is there evidence that brief interventions can work? Yes.

Physicians developed and tested an Integrated Brief Intervention (IBI) with self-defined problem cannabis (marijuana) users in Australia, which has many circumstances similar to Wyoming. The study was small, but promising. Most participants reported a marked reduction in the frequency and/or quantity of cannabis used. Participants also improved health and social functioning.

A United States' study, somewhat better controlled, showed even more positive benefits for a two-session marijuana intervention. <sup>204</sup> Cannabis use, dependence symptoms, and negative consequences were reduced significantly in relation to pretreatment levels at 1-, 4-, 7-, 13-, and 16-month follow-ups

A major short-term effort of this plan is to have an impact on substance abuse in the state of Wyoming. The brief interventions do not have to result in abstinence for the state and its citizens to have major medical or social benefits. Many of the interventions can reduce both immediate harm and long-term harm by reducing the frequency, intensity, and length of use of substances.

#### **Wyoming Recommendation:**

With all due haste, the various departments (Health, Family Services, Workforce Development, Corrections, and Education) must undertake the selection, diffusion, testing, and reimbursement for, brief treatment interventions for substance abuse, misuse, and use in primary care offices, dental practices, psychologists, community mental health, and other providers.

## Marketing Brief Interventions to Practitioners

What does it take to get primary care providers to use brief interventions? Just depending on people to do the right thing is not enough. To date, available evidence suggests that the adoption of

effective brief therapies takes the same kind of marketing efforts that drug companies use to get their products utilized.<sup>206</sup> This includes media, personal visits, tele-marketing and more.

#### **Wyoming Recommendation:**

The state, in partnership with private and non-profit groups, must undertake a powerful marketing program to encourage the use and testing of brief treatment interventions to reduce substance abuse, misuse, and use. This effort will likely yield major short-tem reductions in prevalence rates, setting in motion larger gains and positive community norms.

#### **Brief Interventions in Novel**

#### **Settings**

Primary-care settings are not the best place, nor the most effective place to reach younger adults or some women. Bars are the best places—which is where people drink often to excess, particularly on Fridays and Saturdays. Could brief interventions be launched in bars to reduce substance abuse? The answer appears to be yes, again drawing on science from our Australian colleagues who deal with a cultural context not unlike Wyoming. Like a famous bank robber who was asked why he robbed banks and replied, "That's where the money is.", Australian public health folks went to bars and taverns because "that's where the booze is." The brief intervention took about 5 min. and consisted of a personalized risk

assessment using the Alcohol Use Disorders Identification Test (AUDIT) in combination with a breathalyser to determine blood alcohol concentration (BAC). The scientists followed the bar patrons for 12 months. At follow-up, almost half (46%) the patrons reported reducing their alcohol consumption. The mean AUDIT score reduced by 15%, weekly alcohol consumption by 13% and frequency of binge drinking by 19%. Those previously drinking at 'harmful' levels reduced most (AUDIT 29%, consumption 22% and binge frequency 37%). Females had almost twice the odds of reducing consumption compared to males, as did participants with initial consumption above the mean. Older respondents showed smaller reductions than young people in composite AUDIT score, but greater reductions on consumption and binge frequency scales.

Computer-assisted strategies at home, at schools and colleges, and other office settings show promise in affecting substance use prevalence.<sup>207</sup> Recent evidence suggests that such interventions may be as powerful as brief interventions by the primary care physician, but nearly completely automated in the doctor's office.<sup>208</sup>

The Canadians have been experimenting with such brief interventions in the probation context, and these strategies show some promise. <sup>209</sup>

#### **Wyoming Recommendation:**

The Department of Health, in collaboration with other agencies, non-profits, and community-based services, should undertake a rapid test of brief interventions in novel settings, using novel technologies based on prior promising scientific evidence to reduce substance abuse, misuse, and use.

# **Employee Assistance Programs**

Employers are one of the entities with the potential to exert the coercion necessary to force addicted individuals into treatment and to keep them there long enough for the treatment to work. The Partnership for Recovery is a consortium of the nation's top non-profit treatment providers. Its members include The Hazelden Foundation, The Betty Ford Center, and the Valley Hope Association. The Partnership has extensively studied the role of employers in addictions recovery.

They first point out the costs of not treating employees. Firing them and replacing them is expensive. It costs an average of \$7000 to replace a salaried employee. That cost can go much higher, exceeding \$40,000, for a senior executive. A termination often occurs after the troubled employee has caused other, even more expensive problems for the company.

On the other hand, the Partnership points to numbers gathered by the Substance Abuse and Mental Health Services Administration demonstrating the value of employee assistance programs (EAP's):

- $\Rightarrow$  85% decline in absenteeism,
- $\Rightarrow$  50% drop in injuries, and
- $\Rightarrow$  82% reduction in tardiness.<sup>210</sup>

The United States Small Business Administration reports drug-free workplace programs cost an average of \$22-50 dollars per employee. But, not having a program is not free. Most substance abusers are indeed employed. The Project SAFE ASI project in Casper disclosed 70% of those coming for treatment of addiction are employed. These numbers coincide with national studies. Untreated substance abusing employees cost US business an average of more than \$640 per employee each year.<sup>211</sup>

Indeed, employer use of these programs is preferable to allowing an employee to use until he or she causes a fatal accident or commits a crime and enters the criminal justice system where a different kind of coercion is available. EAP's are important early interventions. It is important to recognize that they not only benefit the company and the employee. Most of these employees also have families. Intervening early in the employee's life will have an undoubted impact on the children.

It is important to note that simply offering an EAP does not require the

employer to pay the cost of treatment. Indeed, we believe it is important for addicts to invest in their own treatment. However, employers who provide insurance benefits should be sensitive to the need to include substance abuse coverage. Other employers have contributed to the cost. Even then, the payoffs are worth the costs. The Small Business Administration can also be a source of assistance to employers.

We encourage the Legislature to provide other positive incentives for employers to develop and use effective Employee Assistance Programs (EAP's). As previously discussed, the statutory framework for accomplishing this goal already exists. W.S. 27-14-201(o) permits the state to discount workers' comp rates for employers who comply with "a safety program approved by the division." Because of solvency problems in the workers' compensation system, this provision has yet to be implemented. It should be implemented to include rules for utilizing drug and alcohol education and an EAP in any safety program.

Additionally, the Substance Abuse Division should provide technical assistance and training to help employers develop and use effective programs. A necessary adjunct to making this work is the enhancement of the treatment delivery system as recommended herein. Unless that is accomplished, cooperative employers will have no place to send troubled employees. When employers create EAP's, they deserve to know that the community program is an effective partner. These kinds of positive

incentives should promote effective use of EAP's

# Involuntary Treatment Commitments

While it is critical to provide treatment for those whose abuse of alcohol or other drugs leads to the commission of crimes, it is equally true that the commission of a crime should not be a necessary prerequisite to receiving treatment. Many times, spouses and other family members are frustrated by the inability of the system to place their drug abusing family member in treatment. While adolescents can be involuntarily placed, that is not true of adults until they commit a crime. Early intervention is the key, not only to effective treatment, but also to protecting public safety.

Accordingly, we urge the Legislature to study measures allowing for the involuntary commitment of those whose abuse of alcohol and/or other drugs results in making him or her a danger to self or others or that the person is incapacitated to such an extent s/he is unable to care for self or dependents.

This proposal is not new. The California Civil Addict Program (CAP) is one of the most successful and most studied. Civil commitment, as implemented in CAP was found to have reduced daily narcotic use and related criminal activity to one-third the levels of addicts not civilly committed.<sup>212</sup> A bill providing the means of involuntarily treating certain addicts was introduced during the 2000 Legislature as HB230.